

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-042828

FILED VS DEC 3 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3051

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b 1 Year	c. CITY OR TOWN University City 30 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda DillworthNH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 6820 Delmar Blvd. (If outside, give location) Castlereagh Apartments Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MATILDA Middle SMITH Last HENNIGAN			4. DATE OF DEATH Month November Day 16 Year 1959		
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/21/1882	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Anthony Wayne Smith		13b. MOTHER'S MAIDEN NAME Catherine Fawcett		14. NAME OF HUSBAND OR WIFE James David Hennigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Franklin Ferriss 440 Oakley Dr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial infarction			10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic cardiovascular disease		years
	DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal parotitis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) -----	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year -----		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----	20f. CITY, TOWN, OR LOCATION -----	COUNTY STATE

21. I attended the deceased from **February 1952** to **November 16, 1959** and last saw her alive on **November 14, 1959**
Death occurred at **10:35** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W Baumgartner</i> M.D.	22b. ADDRESS 3720 Washington Ave.	22c. DATE SIGNED 11/16/1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-burial	23b. DATE 11/18/59	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, Inc. 6175 Delmar	25. DATE RECD. BY LOCAL REG. 11-18-59	26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Walter Baumgarten, Jr.
3720 Washington Ave.
JE. 3 6720

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed jos. e. mc culloch

Licensed Embalmer No. 2260

P. O. Address 6175 Rll

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.